HIV PREVENTION: HOW EFFECTIVE IS THE PRESIDENT'S EMERGENCY PLAN FOR AIDS RELIEF (PEPFAR)? TANZANIA'S EXPERIENCE

Dr. Lucy Nkya

Introduction

AIDS epidemic in Tanzania was first recognized in 1983, when the first three cases were recorded in Kagera region. Three years later 21 regions of Tanzania mainland reported AIDS cases in hospitals. This signified fast spread of the disease making it a potential national disaster. Consequently, the president of Tanzania declared AIDS a national disaster in 2000 when launching National AIDS Policy.

NACP report of 2004 indicated that there were 16,430 new cases reported from 21 regions of Tanzania mainland leading to a cumulative total of 192,532 cases since 1983. The statistics were obtained from hospitals and few HIV care facilities mostly found in urban areas. Based on Estimation and Projection Package (EPP) and spectrum model developed by WHO, only one out of fourteen cases of AIDS are reported in Tanzania. Based on the EPP, therefore, the total number of AIDS cases for 2004 was 1,840,000 leading to cumulative number of 2,675,448 since 1983. The highly affected age group is between 20 – 49 years (73%). Females between ages 20 and 29 are more affected than males while married people form 55.6% of PLHA as compared to 22% of singles. Current HIV infection prevalence rate in Tanzania is estimated at 7.7% which is based on blood donors (NACP, 2004).

In year 2004 the Government of Tanzania planned ARV treatment to an estimated number of 500,000 AIDS patients, most of which were in urban areas. Only those with CD4 count less than 200 were eligible for treatment. This means that a large numbers of HIV cases are not getting ARV treatment. Nutritional support is not part of the treatment package due to lack of funds.

Tanzanian government response to the AIDS epidemic is robust. The National AIDS Policy spells out prevention approaches which include; care, treatment and support to those affected by HIV/AIDS. Education on the use of condom and distribution to high risk groups is one of the approaches. Free access to condoms is no longer possible, however, due to shortage of funds. Abstinence and faithfulness drive is still limited to faith based organizations.

This testimony provides a general overview of PEPFAR in relation to HIV/AIDS situation in Tanzania with reference to Faraja Trust Fund.

What is Faraja Trust Fund?

Faraja Trust fund (referred to as FARAJA) is a community based non-governmental organization with integrated activities on HIV/AIDS prevention, care and treatment. The organization was established in 1991 in response to HIV/AIDS epidemic in Morogoro region of Tanzania.

The mission of FARAJA is to alleviate suffering among the HIV/AIDS vulnerable people and affected individuals through counseling, care and coping support, income generation activities and preventive health education. The vision of FARAJA is to see communities free from suffering arising from the scourge of HIV/AIDS and to become the foremost competent and effective service provider in alleviating suffering through care and support of HIV/AIDS affected individuals in Morogoro Region. The Motto of FARAJA is to *alleviate suffering through building self-help capacity.*

FARAJA started with Commercial Sex Work Resocialization program in 1991 when 270 Commercial Sex Workers were enabled to switch from risky behaviour to other socially acceptable income generating activities. Strategies employed included HIV/AIDS/STI education, information about condom use and distribution and economic empowerment through small grants. As the organization grew, strategies expanded to include HIV/AIDS peer education, counseling and home based care, OVC support, human rights and legal aid, school health program and out of school youths program.

Faraja Experience with PEPFAR

Experience through ISHI Campaign (2004-2005)

Through the agency of Deloitte and Touché FARAJA was provided with $ 7,000 for the 'ISHI' Campaign targeting youth in Morogoro Municipality. The aim of the project was to promote youth's behavioral change, abstinence until marriage, condom promotion, and promotion of voluntary counseling and testing (VCT).

This program was highly successful because many youths turned for VCT and attended youth behavioral change "Wednesday" debates. There was also increased demand for STI treatment and increased demand for condoms. Feedback from beneficiaries confirmed that knowledge about HIV/AIDS/STI was increased by about 90% among youth in the intervention while information about condom and condom use increased by 80%. Those treated for STI'S reported high rate of condom use after treatment. Sex workers acquired skills of negotiating condom use with their beneficiaries who were also interested in knowing their HIV status. Youth living with HIV/AIDS became more willing to disclose their HIV status and joined the campaign against spread of HIV/AIDS as witnesses to the reality of HIV/AIDS epidemic.

Experience through Family Health International (2005-2006)

FARAJA continued with second phase of ISHI Campaigns funded through Family Health International (FHI) where a total of $7000 was provided to target youth in Morogoro Municipality with a focus on abstinence until marriage, behavioral change, promotion of VCT and "no condom" promotion. Sex workers (prostitution) were not part of the programme. In this second phase the campaign style changed and results were mixed.

A number of youths reported that they were confused by the new approach where Faraja seemed to have abandoned their previous focus of advocating behavioral change, abstinence and condoms, and switched to a new moralistic approach of encouraging youth to abstain until marriage, no condom use, and family planning.

Several questions were been asked by beneficiaries of the program, including:

- What will happen to the sexually active youth and adolescents who are living with HIV/AIDS?

- What about the sexual rights of PLHA youths? (The issues at stake here were re-infection, unwanted pregnancies leading to giving birth to HIV+ children and forced early marriages.

Faraja Assessment of the ISHI Campaigns

The concept of AB approach as compared to ABC approach did not take into account the following realities:

- The issues of culture, such as polygamy, parents not discussing reproductive and sex education with their children, behavior of men when they have money, behaviors during folk festivals (initiation ceremonies, witchcraft, raping the young for cleansing and wealth).

- The role of poverty in the spread of HIV/AIDS and its impact on communities in which young women, single mothers and widows are predisposed to HIV.AIDS infection.

- Increased unemployment in developing countries exposes youths to risky behaviours i.e. sex work and drug abuse.

The *bottom-line outcome* arising from the complexity of the HIV/AIDS is that the traditional family support system is rapidly weakening due to rapid urbanization, deaths of parents caused by AIDS and family breakdown. This is contributing to the rapid increase of children and youth living in streets and are exposed to greater risk of contracting STI's and HIV infections due to many reasons.